Questionnaire for Verification of Full-Time Student or Handicapped Adult Dependent Eligibility

a HealthCare

DATE	SUBSCRIBER'S NAME (EMPLOYEE)	DEPENDENT'S NAME	
NAME OF HEALTH PLAN:		HEALTHPLAN CODE:	ID NUMBER
GROUP NAME			GROUP/DIVISION NUMBER

Please complete Section A and B, and
sign/date this Questionnaire on the reverse side.
Please return the Questionnaire with the
appropriate documentation in the enclosed envelope.
Please make sure the return address appears in the window.

ELIGIBILITY SERVICES
PO BOX 5700
SCRANTON, PA 18505

A. Full-Time Student Verification.

_____ Named dependent qualifies for continued coverage under the plan terms (e.g. unmarried, primarily supported by the employee, and enrolled in a secondary school, college or university as a full-time student); please check your booklet/certificate for the plan terms that apply to you. *Note that not all plans contain provisions for student coverage.* Please return this Questionnaire with one of the following forms of verification:

- A copy of the current semester official class schedule reflecting full-time student status &/or total credit hours; OR
- A signed statement from the Registrar or Dean of Students verifying full-time student status; OR
- A copy of the current semester tuition bill showing full-time student status &/or total credit hours

_____ Named dependent does not qualify for continued coverage as a full-time student under the plan terms.
_____ My plan does not contain a provision for full-time student coverage.

B. Handicap/Disabled Dependent Verification

Is this Dependent:
Your natural child, step-child, or adopted child or a child that a court has ordered you to support? ☐ Yes ☐ No
Your grandchild? ☐ Yes ☐ No
Married? ☐ Yes ☐ No
Primarily dependent on you for support or legally dependent on your for support?
☐ Yes ☐ No
Continuously incapable of self-sustaining employment as a result of a mental or physical handicap? ☐ Yes ☐ No
Please describe the mental or physical handicap:

When did this handicap become severe enough to prohibit self-sustaining employment:
Before your child reached the limiting age for a dependent under your plan?
☐ Yes ☐ No
While your child was covered as a full-time student?
☐ Yes ☐ No

Please return this Questionnaire with the enclosed Physician Form completed by the attending physician. If your child has received an Award of Social Security Disability Benefits, you may submit it with your completed Questionnaire instead of the Physician Form.

_____ Named dependent does not qualify for continued coverage as a handicapped dependent under the plan terms.

Verification of dependent eligibility may be requested periodically.

Member Signature: _____Date: _____